Chapter 16
The Impact of Stigma on Transgender Identity Development and Mental Health

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Abstract The existence of transgender and gender-nonconforming people has been documented throughout history and across cultures. In the twentieth century, transgender expression became medicalized and sex reassignment became available, initially enforcing a binary understanding of sex/gender as either male or female, man or woman, and masculine or feminine. The goal was to adjust and live either as a man or as a woman, evading the social stigma attached to gender nonconformity. However, it quickly became clear that stigma was pervasive and continued, even for those who fully transitioned to living as a member of the other sex. Transsexual and transgender individuals found support among each other, affirmed their specific identity and experience, and advocated for their rights. Since the 1990s, the paradigm shifted toward (re)discovery of a spectrum of gender diversity. Transgender is now an identity, no longer a disorder, and identifying as such is for many an important part of their coming-out process to affirm their differentness, find belonging in a community of peers, challenge stigma, and advocate for inclusion, respect, and acceptance. Research has established the association between discrimination and psychological distress, with family support, identity pride, and particularly peer support serving as protective factors. What is needed is a greater understanding of the mechanism of stigma, both for the minority population and for the sociocultural context in which stigma is produced and perpetuated, to inform policies promoting transgender rights and resilience.

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16.1 Historical Background: From Gender Nonconformity to Sex Change

The existence of gender-nonconforming and transgender people has been documented throughout history and across cultures (Bullough & Bullough, 1993; Feinberg, 1996). Examples of such gender diversity include "two-spirit" individuals in Native American tribes (Roscoe, 1991; Williams, 1986), "acault" in Myanmar (Coleman, Colgan, & Gooren, 1992), "maa khii" in Thailand (Taywadietep, Coleman, & Domronggittigule, 1997), "travesti" in Brazil (Kulick, 1998), and "hijras" in India (Nanda, 1999). In the Netherlands, Dekker and van de Pol (1989) reported more than a hundred cases of female cross-dressing (females dressing as men) in the seventeenth and eighteenth centuries. While motivations for cross-dressing and living as man varied (e.g., economic, psychological, sexual, taking on roles only acceptable for men), experiences of stigma (e.g., fear of discovery, negative social reactions) were common across this group despite the popularity of cross-dressing and crossgender behavior in art and folklore. In the nineteenth century, however, cases of female cross-dressing declined markedly, attributed to increased societal barriers (e.g., enforced military service, civil registration, medical exams). The authors concluded that female cross-dressing and living in the male gender role were perceived as threatening the hierarchy between the sexes and that gender ambiguity seemed to put people ill at ease.

In the early twentieth century, when males who cross-dressed faced legal arrest, Hirschfeld (1910/1991) advocated for them by medicalizing transgender expression. He argued that instead of criminalizing cross-dressing and crossgender behavior, people needed to be compassionate as he believed the behavior involved an innate orientation. In the second half of the twentieth century, after behavioral therapies aimed at changing gender identity/expression to become congruent with sex assigned at birth had failed, advances in medical technology were applied to attempt to achieve the opposite: to change an individual's primary and secondary sex characteristics to become congruent with their perceived gender identity (Benjamin, 1966; Green & Money, 1969; Hastings, 1974). Indeed, this approach of sex reassignment became known in the popular vernacular as "sex change" (Meyerowitz, 2002). While Benjamin (1966) acknowledged a spectrum of transvestism and transsexualism, much of the focus shifted toward selecting appropriate candidates for hormone therapy and surgery who could successfully "pass" and assimilate as members of the "opposite" sex. The aim was to alleviate their suffering by facilitating a change in sex while minimizing the risk of regret of undergoing irreversible medical intervention (Hastings, 1969; 1974; Hastings & Markland, 1978).

Also in the Netherlands, sex reassignment became available coordinated by the *Stichting Nederlands Gender Centrum* (de Vaal, 1971; Verschoor, 1986). The VU University Medical Center (VUmc) provided hormone therapy and surgery (Gooren, Asscheman, & Megens 1986). Post hoc follow-up research supported the value of sex reassignment in alleviating gender dysphoria: The vast majority of transsexual individuals who received hormone therapy and had sex reassignment surgery

reported satisfaction (Kuiper, 1991), and reports of regrets were extremely rare (Kuiper & Cohen-Kettenis, 1998). The VUmc became an international leader in patient-oriented research reporting on the long-term effects of hormone therapy in a large cohort of transsexual adults (e.g., van Kesteren, Asscheman, Megens, & Gooren, 2003). Initiated in collaboration with Utrecht University, the Dutch also pioneered early medical intervention in the form of puberty-delaying hormones followed by cross-sex hormone therapy (Cohen-Kettenis & van Goozen, 1998; Delemarre-van de Waal & Cohen-Kettenis, 2006), which has now become an approach applied worldwide (Coleman et al., 2012). Moreover, research at the Netherlands Institute for Brain Research showed that an area of the hypothalamus of the brain of transsexual women was more similar to that of nontransgender women than to that of men (Kruijver et al., 2000; Zhou, Hoffman, Gooren, & Swaab, 1995). At the height of the sex change paradigm in the Netherlands, some argued for replacing the term "sex reassignment" with *detransseksualisatie* (detranssexualization) to affirm transsexual (or, rather, "transsexed") individuals' lifelong core crossgender identity and the success of the available treatment to fulfill their need to live as members of the "opposite" sex (Kuiper, 1991; Verschoor, 1986).

16.2 Social Stigma: From *Detransseksualisatie* to Transgender Coming Out

Since the 1990s, first in the USA and subsequently also in Western Europe, the paradigm shifted from seeing gender identity as binary (either boy/man or girl/woman) toward (re)discovery of a spectrum of gender diversity. As a generation of sex-reassigned transsexuals came of age, recognition grew of a transsexual or transgender identity "outside the boundaries of gender, beyond the constructed oppositional nodes" of male versus female (Stone, 1991, p. 295). Transsexual and transgender individuals began to affirm their identity as distinct from nontransgender women and men, honoring their specific experience and roots (e.g., Bornstein, 1994). This change in paradigm can be understood in the context of social stigma. As Pfäfflin (2011; see Chap. 17) argued, identity becomes relevant when it is no longer assumed but questioned, when we are dealing with a deficit. Thus, the social stigma attached to gender nonconformity (deficit) created the need to "come out" and affirm an identity that transcends the gender binary.

In the transgender coming-out process, support from similar others plays a critical role (Bockting & Coleman, 2007). According to Erikson (1956), identity development is an interactive, social process during which an individual learns to experience himself or herself as unique and continuous across time and situations (personal identity), while at the same time belonging to a social group (group identity). During the sex change paradigm of the 1960s and 1970s, "true transsexual" candidates for sex reassignment were to find a sense of belonging among nontransgender women and men. However, "transvestites," whose crossgender identification

was considered incomplete or ambiguous (Benjamin, 1966), sought and found each other. In the USA, Virginia Prince founded the peer support organization Tri-Ess: the Society for the Second Self. Virginia eventually lived full time in the female gender role yet was vocal about not having had genital reconstructive surgery. She popularized the term "transgender" as an alternative to "transsexual" and "transvestite" to signify an identity that transcended the gender binary and was continuous. Meanwhile, participants in the Gender Identity Project in New York City proposed to spell "tran*s*exual" with one "s" to signify an ongoing identity beyond the transition phase and challenged the shame associated with the pressure to pass as nontransgender in favor of affirming their specific shared identity and experience (Warren, 1993). The following quote illustrates this transformative change:

> "*Often we want to pass as non-transexuals because of an unexpressed conviction that only non-transexual women define femaleness … I used to say, 'Well sometimes I still sound like a man.' And then it occurred to me. I don't sound like a man. I sound just exactly and precisely like a transexual woman … I used to feel embarrassed because I had 'man's hands or a 'man's build.' But I don't. I have the hands and build of a transexual woman. I stopped defining myself in terms of other people's categories and started defining myself in terms of me*" (Warren, 1993, p. 16).

In the Netherlands, the *Nederlandse Vereniging voor Seksuele Hervorming* (NVSH) had long organized peer support through its *Travestie & Transseksualiteit (T&T)* network, followed by such support organizations as *Het Jongensuur*, *Stichting Rene(e)*, *Humanitas*, *Transvisie*, and *Transgender Netwerk Nederland*.

Gradually, as transsexual and transgender individuals built community and gained visibility, the term transgender evolved into an umbrella term blurring the clear distinction between transvestites and transsexuals, allowing for the recognition of a wide spectrum of gender diversity (Bockting, 1999; De Jong, 1999). Changes in gender role, hormone therapy, and surgery were no longer considered three steps in a linear process of sex reassignment but rather three options that individuals may utilize to varying degrees to actualize their particular transgender identity (Bockting, 2008). Finally, genderqueer emerged as a term especially popular among the younger generation to affirm their transgression from the gender binary (Bockting, 2008; Harrison, Grant, & Herman, 2012). Recently, however, some transsexual activists have argued that they do not experience their gender identity as variant but rather as completely on the other end of the gender spectrum, reaffirming the term "transsexual" to distinguish themselves from gender-variant and gender-nonconforming individuals. To be inclusive of both transgender- and transsexual-identified individuals, the short form "trans" is now often used.

Thus, in the context of social stigma, transgender identities emerge to affirm gender nonconformity and empower transgender people to develop resilience. This process is similar to the coming-out process of gay and lesbian individuals (see Bockting & Coleman, 2007), and it is therefore not surprising that the transgender (T) community established a strong coalition with the lesbian, gay, and bisexual (LGB) community in the shared concern and fight against stigma, which for LGB individuals also often centers around gender role nonconformity. While gender identity and sexual orientation are distinct components of one's sexual identity,

nonconformity to what Butler (1991) called "the heterosexual matrix" creates common ground for LGBT people to affirm their identity and experience within a community of similar others, a process of empowerment (Bockting, Rosser, & Coleman, 1999), resilience (Bockting, Miner, Swinburne Romine, & Coleman, 2013), or minority stress coping (Meyer, 2003).

16.3 Minority Stress, Mental Health, and Resilience

Transsexual and transgender individuals face persistent and intense stigma. For example, in a national study of the US transgender population, 70 % reported verbal abuse and harassment related to being transgender and 38 % reported employment discrimination (Bockting et al., 2013). In a recent national survey in the Netherlands, 42 % reported having received negative reactions because of their transgender identity, most commonly in public (38 %) and at work or school (21 %) (Keuzenkamp, 2012). The minority stress model (Meyer, 2003) postulates that stigma attached to one's minority status creates added stress beyond general stress that individuals from both the majority and minority populations face. This added stress then is expected to negatively affect mental health and other health outcomes. However, minority stress-coping processes or resiliency factors may ameliorate the negative impact of stigma on mental health. Minority stress-coping processes can operate on an individual or community level and include personal acceptance and integration of minority identity; peer support, community solidarity, and cohesiveness; and family support (Meyer, 2003). A community of peers not only provides a space where one is not stigmatized by others but also provides an alternative reference group to evaluate oneself in comparison to similar others rather than with members of the majority population.

The minority stress model has been tested with LGB populations, leading to greater understanding of the LGB population's vulnerability to mental health concerns (e.g., Lehavot & Simoni, 2011; Lewis, Derlega, Brown, Rose, & Henson, 2009; Meyer, 1995). However, until recently, this model had not been tested with the transgender population. Five recent quantitative studies established the negative association between stigma and mental health among the transgender population in North America. Discrimination related to being transgender was identified as an independent predictor of suicide among transgender women and men in San Francisco (Clements-Nolle, Marx, & Katz, 2006). Also in San Francisco, among transgender women with a history of sex work, discrimination and the need for social support were positively associated with depression (Nemoto, Bödeker, & Iwamoto, 2011). Among transgender women in New York City, gender-related abuse was strongly associated with depression during early stages of life but, especially for the younger generation, declined during later stages of life, attributed to the development of moderately effective coping mechanisms (Nuttbrock et al., 2010). Among a sample of the transgender population recruited via respondent-driven sampling in Ontario, Canada, rates of depression were high (61 % for transgender women and 66 % for transgender men), and depression was associated with

transgender-related stigma and discrimination (Rotondi, Bauer, Scanlon et al., 2011; Rotondi, Bauer, Travers et al., 2011). Finally, three factors of resilience (identity pride, family support, and transgender peer support) were tested in a large Internet-based sample of the US transgender population (Bockting et al., 2013). Using a standardized instrument, 49 % of transgender women and 37 % of transgender men reported clinical levels of depression; 33 % of each gender group reported clinical levels of anxiety. Both enacted stigma (actual experiences of discrimination) and felt stigma (stigma consciousness, anticipated or perceived rejection) were positively associated with overall psychological distress. While self-acceptance and a sense of pride in being transgender as well as support from family were both negatively associated with psychological distress (i.e., the more pride and support, the less psychological distress), support from transgender peers was the only protective factor to moderate and thus buffer the negative impact of stigma on mental health.

16.4 Stigma and Transgender Identity Development

As argued above, affirmation of a transgender identity becomes especially salient in the context of social stigma attached to gender nonconformity. The transgender population is diverse and many attempts have been made to categorize gender-variant individuals, and especially when it comes to transgender women, a number of typologies have been proposed (see Bockting, in press, for an overview). Notwithstanding differences between the various typologies, a common understanding is that there are two groups of transsexual women: one group with an onset of crossgender feelings and identity in childhood and another group with an onset in adolescence or adulthood (Nieder et al., 2011). These two groups have been found to differ in sexual orientation and mental health (Lawrence, 2010). When we consider the role of stigma in transgender identity development, the difference of nonconformity in gender *role* between the two groups becomes salient.

Children who are visibly gender role nonconforming in childhood have no choice but to learn to cope with the attached enacted stigma at an early age. Their coming-out process is accelerated. Stigma and rejection at an early age put these gender-nonconforming youth at risk for isolation, academic performance issues and school dropout, homelessness, substance abuse, and suicide (Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman and D'Augelli 2007; Sausa, 2005; Wyss, 2004). However, it also provides the opportunity to develop early resilience. Due to visible gender role nonconformity, their gender identity is noticed and accurately mirrored, aiding in the development of a coherent sense of self, albeit a nonconforming self. In contrast, those who are not visibly gender role nonconforming in childhood are able to hide and suppress their crossgender feelings. Their gender identity is not noticed, and what is mirrored is the gender identity they maintain to the outside world in accordance with what is expected of them. Their coming out is delayed. Felt stigma and shame puts these youth at risk for developing obsessive/compulsive features of cross-dressing and gender dysphoria and may result in leading a double

life that takes its toll on their mental health. Thus, stigma affects the identity development of gender-r*ole*-conforming and gender-*role*-nonconforming children and adolescents differently, with profound impact on their human development and mental health.

Grounded in interactionist (Erikson, 1956; Plummer, 1975) and interpersonal theory (Sullivan, 1953) and informed by extensive clinical experience, a stage model of gay and lesbian identity development was adapted to transgender identity development (Bockting & Coleman, 2007). In the first phase, *Pre-Coming Out*, transgender feelings are present yet have not been named as such. Rather, there is a growing awareness of being different, with accompanying shame and alienation from others. The developmental task of this stage is to face this differentness and begin to move toward the second stage, *Coming Out*, by acknowledging transgender feelings to self and others. The developmental task of this second stage is to resolve any confusion about transgender feelings and achieve self-acceptance. The response of others is critical, especially in the beginning. Positive reactions can lessen shame and reduce isolation, while negative reactions reinforce it, delay further coming out, and increase vulnerability to self-harm and suicide. Therefore, taking calculated risks by first disclosing to those who are most likely to be accepting is recommended. But even then, immediate acceptance may not be realistic; support from others (counselor or transgender peers) can be instrumental in putting reactions from others in perspective.

The third stage, *Exploration*, is the time to learn as much as possible about being transgender through immersion in available resources and the community, both online and off-line. The first developmental task of this stage is experimentation to find a comfortable gender role and expression. This may include the pursuit of hormone therapy and/or surgery. The second developmental task is to achieve a sense of personal attractiveness and sexual competence, which for some includes a second adolescence. Completion of this stage involves transforming shame into pride and working through any internalized transphobia, often through participation in community organizing and activism.

In the fourth stage, *Intimacy*, the focus shifts from the relationship with oneself to fulfilling the desire for close relationships with others. The developmental tasks of establishing and maintaining intimate relationships may be complicated by a history of anxious attachments. It may be further complicated by the impact of stigma on partners, who, for example, may hesitate to introduce a transgender partner to their family. However, with practice and perseverance, these challenges can be overcome; many transgender individuals report being in committed relationships (Bockting, Benner, & Coleman, 2009; Iantaffi & Bockting, 2011; Lawrence, 2005). Finally, in the fifth stage, *Integration*, being transgender becomes an integral part of a person's overall identity. The developmental task of this stage is to come to a deeper level of self-acceptance and appreciate the added value of being transgender. Having found a comfortable gender role expressed in relationship with others, identity labels become less important and there is room for greater ambiguity. If questions arise around one's gender identity, these questions can be addressed with confidence. There is a shift in focus to pursue other life goals and aspirations. This may also be a time of giving back to the community and/or taking on leadership roles in society more generally.

16.5 Implications for Clinical Practice and Advocacy

Clinicians can play an invaluable role in facilitating identity development, promoting the health and mental health, and improving the quality of life of transgender individuals and their families. While hormone therapy and/or surgery are medically necessary for many transsexual and transgender individuals, finding a comfortable gender role and expression is in large part a psychosocial process. Moreover, growing up with a stigmatized identity poses challenges for human development that may take its toll on mental health. Mental health professionals can help in at least four important ways: (1) assess and treat the negative effects of stigma on mental health, (2) facilitate identity development, (3) foster resilience in coping with ongoing stigma, and (4) engage in advocacy to combat social stigma.

The Standards of Care for the health of transsexual, transgender, and gender-nonconforming people (Coleman et al., 2012) guide health professionals in providing transgender-specific health care. It includes guidelines for mental health professionals. While a psychological evaluation is no longer an absolute requirement in the Standards of Care for access to hormone therapy, referral for such an evaluation is recommended, particularly when a mental health screen identifies significant mental health concerns. Treatment of depression and other mental health conditions can greatly facilitate completion of the developmental tasks of the coming-out process (Bockting & Coleman, 2007; Bockting, Knudson, & Goldberg, 2006; Fraser, 2009). Fostering family support, identity pride, and particularly peer support will offer protection. In addition, teaching specific stigma-management skills (e.g., putting reactions of others in perspective, assertiveness, personal advocacy, problem solving, rallying support) can empower transgender individuals and their families to improve the capacity of their community to respect, accommodate, and accept them. Finally, health professionals can engage in advocacy on a family, community, and society level to fight stigma and create an environment in which transsexual and transgender people can thrive and gender diversity is celebrated. For example, health professionals can educate and provide resources for families with a transgender loved one, facilitate gender role transitions in the workplace, educate the courts through expert witness testimony during civil cases, and advocate for transgender inclusion in human rights protection legislation.

16.6 Directions for Future Research

In recent years, advocacy efforts for transgender rights around the world have continued to grow. LGBT organizations are finally taking the "T" seriously and are putting their weight, leverage, and resources behind transgender causes. In addition, community organizations specifically dedicated to the needs of the transgender population are making new advances by using a human rights framework (i.e., the right to universal health care for all) to promote the health and well-being of

transsexual, transgender, and gender-nonconforming individuals and their families. To support these positive developments and to facilitate further progress, research to inform evidence-based policy decisions is urgently needed. For example, research on the effects of gender affirmation on the mental health and psychosocial adjustment of transgender youth or on the cost-effectiveness of transgender-specific health care (including surgery) could inform policy that ensures greater access to care.

In the period 1960–1990, research in transgender health was mostly clinical, patient-oriented research (Institute of Medicine, 2011). Since the 1990s, a public health approach to transgender health research emerged, largely spurred by the impact of the HIV epidemic on the transgender population (e.g., Bockting & Avery, 2005). This body of research indicated that HIV was highly prevalent among subgroups of the population that face multiple, compounding challenges—many driven by social stigma—such as poverty, discrimination and violence, depression and suicide, and lack of access to culturally and clinically competent general as well as transgender-specific health care (Lombardi., 2010). Thus, while HIV remains a major concern among the transgender population, other stigma-related health issues need investigation. Health inequities in some of these other areas are beginning to be documented (e.g., Bockting et al., 2013; Rotondi, Bauer, Scanlon et al., 2011; Rotondi, Bauer, Travers et al., 2011), despite the methodological challenges of epidemiological research with a geographically dispersed, relatively small, and "hidden" population, for which a sampling frame to draw a representative sample remains unavailable.

What is needed next are longitudinal cohort studies of diverse segments of the transgender population to examine the *processes* of stigma, minority stress, health, and resilience. A greater understanding of effective coping with stigma can inform the development of evidence-based prevention strategies. What is also needed are studies that advance our understanding of the *mechanism* by which stigma negatively impacts mental health and other health outcomes and the development and evaluation of corresponding intervention strategies (e.g., Hatzenbuehler, 2009; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). Finally, research that increases our understanding of gender-related stigma on an individual, group, community, and society level is needed to guide interventions to reduce ignorance among majority populations and policy makers and to enhance successful integration of transsexual, transgender, and gender-nonconforming people into society.

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